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BEHAVIOR MODIFICATION AND HUMAN RIGHTS: A LEGACY OF EDWARD STANTON SULZER, 1930-1970

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ABSTRACT

Edward Stanton Sulzer was born in New York City on June 4, 1930. He attended school in Laureltown, N.Y., until the age of 15, when, after two years of high school, he was admitted into the University of Chicago. Leaving prematurely due to his mother's death, he returned to New York to work in film production. Sulzer completed his undergraduate work at the City College of New York, studying film production and psychology. In 1953 he entered the doctoral program in clinical psychology at Teachers College, Columbia. Spending two years in the Army during his graduate training, his work was completed in 1958. He then joined the faculty of the Upstate Medical School of the State University of New York, Department of Psychiatry, moving on two years later to the Psychiatry Department at the University of Minnesota. In 1965 Sulzer moved to assume the directorship of the Behavior Modification Program, in the Rehabilitation Institute at Southern Illinois University, where he remained until his death on February 28, 1970.

In observance of the 10th anniversary of the death of Edward Stanton Sulzer, these reminiscences are presented. They describe how an individual psychologist could affect the professional and personal lives of many. Edward Sulzer is described in terms of the environment that shaped his values, how they affected the actions of his students and clients, and how they are reflected in current social policy. The account leads to a conclusion that the actions of single individuals may influence the course of human events.

February 28, 1980 marked a decade since the death of Edward Stanton Sulzer. As his wife for 16 years, I was in a unique position to share his involvement in the early historical development of the field of behavior modification. I was also able to witness the ethical and philosophical perspectives of one man who was acutely concerned with human values and who, in a sense, epitomized a growing concern for individual liberty in our society. The intention, here, then is to recount some of the episodes in his life so that those who have joined the field within the past decade may become acquainted with the thoughts and activities of one of its important progenitors. At Southern Illinois University he served as the Director of the first formally constituted graduate training program in Behavior Modification.

This paper is based on a colloquium presented to the Rehabilitation Institute, Southern Illinois University, May, 1979. I would also like to express my thanks to those people who have given editorial advice: Martin J. Pollack, Ellen P. Reese and Malgorzata Ziajka.

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This paper presents the context out of which Ed's concern for human liberty developed, from a cultural perspective, recounting some of his personal experiences and describing the environment that shaped his ideas and attitudes towards the ethically responsible development of the field of behavior modification. It describes how many of those ideas have been incorporated into policies and practices of human service agencies, and into state and federal laws and judicial decisions. Finally, it describes some of the problems of human rights that exist today that need to be rectified, hoping that others will make similar efforts in behalf of their fellow human beings.

Ed and I were married in 1953. Those of you who remember from your own experience or from reading the history books, are aware that that was towards the end of the "McCarthy Era." (Senator Joseph McCarthy of Wisconsin headed a committee to investigate subversive political activities in the United States from 1950 to 1954.) McCarthyism in the United States epitomized a trend towards repression. The Second World War was over. We had been allied with the Soviets,

but it soon became clear that they constituted a political threat to democracy. So within the next few years, a backlash of fear and antagonism towards Communism began to develop. So extreme was that reaction that even those who had no involvement in Communist activities were often suspected and denounced. Written phrases, taken out of context, casual encounters with identified Communists, were enough to brand an individual.

Watching the McCarthy hearings on television, we saw many people—writers, artists, scholars, educators—unjustly accused of being traitors, either directly or by innuendo. Many had no opportunity to defend themselves. They lost their jobs and their potential for obtaining employment elsewhere. They were damned simply by the fact that they were mentioned or questioned within the halls of Congress.

That was part of the general political aura of the time. At the same time, one saw a parallel development in many other areas. I had started teaching in New York City in the early 1950's. I remember that one of the first pieces of advice I was given by my fellow teachers was, "If you want to get tenure in the New York City School System, don't join the union." (It was suspected of being radical.) And none of us did because our jobs meant a lot to us. Similar excesses were occurring in the treatment of the handicapped people, of mental patients, of criminals, and of racial, religious and other minorities in our population. There were all sorts of injustices and violations of civil and human rights.

This was the context out of which Ed's concerns developed. He was, as those of you who knew him can attest, a person who was very deeply concerned with the human condition, with personal liberty and civil rights; and he joined the effort to improve those conditions. He wasn't just a person who expressed his concern by sitting on the sidelines lamenting about injustice. He was an individual who acted on his beliefs. Perhaps Ed's experiences may serve as a model of a person who would wage an almost independent battle of principle.

Let me illustrate by recounting some experiences. After he finished his course work at Columbia, we moved to Syracuse where he joined the faculty of the State University of New York, Upstate Medical Center. There Ed came in close contact with Tom Szasz. Szasz was trying to dispel the "myth of mental illness," taking issue with our treatment of the "mentally ill" (e.g., Szasz, 1961). Ed was influenced by Tom's perspectives, and began analyzing the treatment of the involuntarily committed mental patient differently. He began to listen to his patients and to note how current and past events in their lives related to their behavior. That perspective matched the conception of human behavior that he had acquired at Columbia while studying Keller and Schoenfeld's text (1950), and reading the works of B. F. Skinner. Tom had conceptualized "mental illness," not as an illness in the medical sense, but rather as a set of problems in living. The behavioral model permitted an explanation of how many problem behaviors might have been shaped and maintained.

By the time Ed joined the University of Minnesota Medical School, he was convinced that if people were experiencing serious behavioral problems, they would profit more from effective instruction than from medical healing. He was also convinced that individuals should be the primary determiners of what happens to them. It was a dual concept, combining the values of individual freedom and human rights, with a deterministic philosophy of behaviorism. Ed soon became an active proponent of this position.

I remember several episodes in which Ed's behavior resembled that of Don Quixote in combat with the windmills. He wrote articles exposing the ways in which the "mentally ill" were mistreated. For example, his paper entitled "Individual

Freedom, Law and Social Welfare" (Sulzer, 1967) recounted several distressing episodes. Patients who had been involuntarily committed to mental hospitals or their families would seek his assistance. In one case a man was hauled off, locked up, and not told why. He was not allowed access to an attorney; was not permitted to call his wife; was not told what he was charged with; was not informed of any recourse available to him. His wife, who was not informed as to his whereabouts, called the police. Finally she tracked him down and found that he had been placed in a locked ward of a hospital. She had no idea why he had been brought there. She was not permitted to see him nor could she meet with the person who was responsible for his being there. She got into a taxi to go home, not knowing what else to do, and burst into tears. The taxi driver suggested she contact an attorney, which she did. The attorney then began to piece together the story. Apparently, the commitment papers had been signed by a social worker who was nowhere on the scene. The attorney arranged a transfer into a jail, where at least the client had access to an attorney, a telephone, and some of the other rights afforded criminals.

If you were involuntarily committed in those years you had few rights. In many states you did not necessarily have access to an attorney, nor access to a telephone. You could have been treated without your permission with such procedures as chemotherapy, hydrotherapy, restraint, electro-convulsive shock, a pre-frontal lobotomy, etc., and there was little accountability to anyone. How might you have gotten into the hospital? You could have gotten there, just as this young man did, by somebody alleging that you were mentally ill or dangerous. Your neighbor could call and say you were disturbing the peace; your wife or child could call and say you were behaving oddly; somebody down the street could have you committed; the family doctor could do it. That's the way it sometimes happened. The protections were minimal if you were involuntarily committed. (Except, of course, if you were wealthy and powerful. In that case things like that usually didn't happen to you.) Many people were placed forcibly in mental hospitals and, once there, often had a very difficult time getting out. As a matter of fact many never did. In one of his papers (Sulzer, 1966) Ed noted at the time of his writing, that approximately 36% of men admitted for the first time into a mental hospital died within three years. Those are pretty powerful statistics. Of course, many of the people who were admitted were very advanced in years, and maybe that fact accounted for some, but surely not all!

People were often confined to a mental hospital with the justification that they were "in need of treatment." And as a matter of fact, in many of the states in the United States at that time, that was the sole criteria for admitting someone into a mental hospital. Assuming you've read some of the books published in the interim, such as "One Flew Over the Cuckoo's Nest," (Kesey, 1961) or "Asylums" (Goffman, 1961), you know that custodial care often took precedence over effective treatment. Certainly effective treatment was often provided in hospitals—but in those institutions where many of the residents had been involuntarily committed little was happening in the way of constructive treatment.

Ed became active as a consultant to, and an advocate for, former mental patients who had formed self-help groups. He was also interviewed for newspapers and radio, and of course wrote and spoke with his professional colleagues. At the University he held seminars on ethics and the law. He testified as an expert witness in commitment hearings and volunteered his time and knowledge whenever he felt he had something of value to share.

Another of Ed's experiences illustrates how he acted to promote client rights. It occurred in the mid-sixties, towards the end of our stay in Minnesota. Legislative

hearings were being held on the commitment of mental patients, and Ed was called to testify. He discussed client rights and the current status of treatment (or lack of) for the mentally ill. Five years later (it took that long) the statutes in Minnesota were changed, permitting many more rights to the person labeled "mentally ill." Probably Ed's expressed concerns contributed toward the legislative reform.

Similar injustices, of course, were taking place with mentally retarded clients, those with epilepsy, and with many other disabled people in our society. A direct parallel could be seen with the treatment of the retarded. When a child was born with a clearly identifiable impairment, such as Down's syndrome, or hydrocephaly, the child would often be placed in an institution at as early an age as possible, the notion being that treatment or care would be provided. Those of us who worked in institutions for the retarded at that time realized that treatment and training were often minimal. One saw crowded wards of people sitting and rocking, abusing themselves, urinating on the floor, and so on. They were usually provided minimal care by staff unable to cope. Often they became ill and many died young. The attitude seemed to be "Let's get these people out of our sight. We don't want to see them. If we don't see them we won't know they're here, and we won't have to do anything about them."

Those attitudes and practices continued well into the sixties. Then we began to see the glimmer of change. Some changes coincided with the outcry of popular arousal over Viet Nam. People became increasingly more concerned with the treatment of fellow human beings. This was also apparent in the Civil Rights movement as people questioned the status quo. "Are we going to pretend that the problems aren't there and hope, by this pretense that they go away?" People began to be more involved in activities such as reform in policies affecting people with retarded mental development and those with severe behavioral disturbances. Simultaneously, effective treatment strategies were being developed. It was in this realm that Ed made his most major contributions. For, in addition to trying to alleviate abuses, he stressed the necessity for substituting more constructive action. And so, during this period of time he focused the primary portion of his professional attention on a number of different areas. Recognizing the extensive potential of the behavioral approach and how it could help people help themselves more effectively, he began to use behavioral principles in designing and implementing treatment programs. Impressed by the work of Ted Ayllon and Nate Azrin and others who demonstrated how behavioral strategies assisted mental patients and the retarded to achieve an improved quality of life, he drew upon their methods and developed many of his own.

At about that time Ed and I began to work together with an autistic child and his parents. I taught the child to follow simple instructions and some functional language. He worked with the parents, teaching them to manage the environment, to become more consistently responsive, and the youngster began to acquire a much more adaptive repertoire. We were pretty excited about some of the outcomes. Thus, looking for effective strategies tended to become his major focus. Treatment would not be just a euphemism for custodial care. Rather "treatment" would be synonomous with "teaching."

But that was just the beginning because there were two other aspects of this concern—accountability and individuality. Ed recognized the shortcomings of the prevalent practice of accepting evidence of treatment effectiveness on faith and saw the need to demonstrate results objectively. There again was the appeal of the behavior modification approach—the fact that it was accountable, that

measurement was objective and that there were methods for increasing its reliability and validity. The data would say, "Keep going" or "Stop. Shift. Go some other way; or change your goals or change your procedures," thus avoiding arbitrary judgments of what was right and good for a person or what intervention was working effectively or what wasn't.

The other critical aspect was the individuality of the approach. People were viewed as distinct from one another, with their own individual rights, and the ability to control their own destiny. Ed was concerned regardless of whether the person had problems in living, was a prisoner, or held membership in any group that tended to be treated as "second class citizens" by society. He consulted with people who were attempting to realize their own goals; not the goals that Ed or others thought were right for them, but what individuals thought were right for themselves. Even children sufficiently mature to identify their own goals would be heard. Perhaps the parents could act in concert with the child. If the child were unable to communicate, someone could serve as an advocate, representing the child's perspective. An example is a brief case study (Sulzer, 1965). A young man with a history of frequent intoxication had unsuccessfully tried traditional psychotherapy. Ed asked what he wished to accomplish and under what circumstances. The client didn't want to give up going to bars because his job required his frequenting them from time to time, and he was unwilling to give up the social conviviality they provided. Ed and the client were able to mutually negotiate an acceptable program which permitted treatment to proceed in the community rather than in a detoxification ward. The assistance of friends was enlisted. They agreed to only socialize with him while he was not drinking alcoholic beverages. The program successfully eliminated the client's excessive alcohol consumption.

It was on the basis of such experiences and concern for the individual that Ed began to conceive of the Therapeutic Contract (Sulzer, 1962). The notion of therapeutic contracting is familiar to most mental health service providers today. In the early 1960's mutually negotiated treatment plans were not typical. In his article, "Reinforcement and the Therapeutic Contract," Ed asserted that psychotherapy is a learning procedure. It was probably the first published statement recommending that the content, potential methods of behavioral treatment and the nature of the relationship between the therapist and client be made explicit as a contractual arrangement. The contract would indicate who would control what contingencies. Therapists were required to consider for whom they functioned as an agent. "For whom am I working?" "To whom do *I* have to provide reinforcement so I in turn can receive reinforcement; so I can keep my job; so nobody gives me any grief?" Roles were to be clarified.

Honest explication of the nature of a relationship doesn't sound terribly dramatic by current standards until it is seen against the context of what was happening in the early 60's. At that time providers of mental health services often acted unilaterally, without consulting clients as to their wishes. Often then, the therapists' goals remained covert. Thus, specifying the content of the therapeutic contract, the behaviors to be targeted, and how they would be treated, and clarifying how the contract could be modified, enhanced openness and honesty in the therapeutic relationship. Confidentiality was also to be assured. From today's perspective, the notion of confidentiality is generally accepted. But at that time many people felt perfectly free to discuss their therapeutic experiences with others.

Those then were the critical elements of the therapeutic contract. You can see how these various aspects would serve to protect the rights of the individual.

A dramatic episode illustrates a popular

perspective held by many mental health professionals. We were about to move to Southern Illinois. It was 1965. Ed was invited to give a speech at a social welfare conference in Atlantic City (Sulzer, 1967). He told the audience about the inadequacy of the law; questioned the practice of judging what's best for clients without consulting with them, and discussed other mis-uses and abuses in the human services field. And he talked about constructive alternatives. People were very moved.

After the talk was over, we adjourned to a restaurant in the hotel. The assembled group included a reporter from a major newspaper, several friends and acquaintances, and a senior officer in a mental health organization. This man turned towards Ed and waited until everyone was quiet so he had command of the audience. Looking at him directly he said, "Edward Sulzer, you are one of the most dangerous men in the United States today." After recovering from the shock, we realized that in a way it was not totally uncomplimentary. People must have been listening there because he wouldn't have considered Ed dangerous if he thought that nobody heard him.

Ed never stopped advocating individual rights. But, the main focus of his attention was directed towards developing and testing interventions to assist people to solve their problems in living, and to teach others to use behavior modification skills responsibly. At Southern Illinois University with the help of Guy Renzaglia, Nathan Azrin, Teodoro Ayllon, and other faculty, a master's degree program in behavior modification was established. It was the first formal program with such a title in the United States. Apparently the *zeitgeist* was right for supporting training in behavior modification. For simultaneously or soon afterwards many programs began to provide major offerings in the discipline: The Kansas Human Development program, The University of Illinois, and later Drake, St. Cloud, and many others. The SIU Program served as a model and people wanted to know all about it. Visitors came to give colloquia, consult and speak, or just to look and they went away with a lot of ideas, often replicating them in their own settings.

Throughout it, Ed continued his activities on behalf of the citizens of our society who were accorded *de facto* second class status. Simultaneously he sensitized his students to ethical issues in seminars and discussion groups, helping them to become aware of the nature of the past and present abuses and how they could be avoided.

In early 1970, Ed passed away. Since then much has happened in human services. Consider how the issues on client rights raised by Ed are related to the events of the past decade. First, laws have been altered to increase protection to people facing involuntary commitment. For example, in the Donaldson case (Donaldson, 1975) it was judged that clients could not be placed involuntarily in a highly restrictive environment without safeguards and without a justification for the placement. People may no longer be placed in settings more restrictive than effective treatment requires. In the Donaldson case, a psychiatrist was held liable and required to pay money for maltreating a patient. In years prior, psychiatrists in state institutions simply had not been successfully sued for negligence, (a point Ed made in one of his papers, Sulzer, 1966).

Various court rulings have also insisted upon objective evidence that treatment was taking place. In Morales v. Terman (1973) it was judged that the service providers had to be able to demonstrate the effectiveness of the treatment they applied. Such examples illustrate judicial reform. Probably the clearest recent illustration of the protection of client rights relates not to the psychiatric patient but disabled children—the Education for All Handicapped Children Act (PL. 94.142). The law protects the rights of disabled

children in various ways. Many safeguards have been incorporated. For instance, with the specification of due process provisions, parents must be informed regularly as to actions planned for their children. Parents are to be informed in writing if their child is being considered for special services. They have the right to appeal. They can contest the plans for their handicapped child; they're allowed to see their child's records. When able to participate, the handicapped child may join the parents who are actively involved. The 94.142 legislation demands accountability. If it is asserted that a student is being taught or if an educational plan is being implemented, evidence of actual progress toward the accomplishment of those goals must be shown. Data are to be objective and valid, measuring the behavior they are supposed to measure.

Another recently evolving focus is in the area of assessing professional competency. There is a growing tendency to try to objectively specify and directly assess how effectively service providers perform specific skills, prior to certifying competence. For instance, at Mansfield Training School, several of my colleagues and I conducted an extensive survey among experts in the field to identify the knowledge and skills that competent behavior analysts should be able to demonstrate (Sulzer-Azaroff, Thaw, & Thomas, 1975). This trend exists in many fields. Passing one written examination is not necessarily any longer considered sufficient evidence that one can teach children or provide services in an institution. More and more, assessment of qualifications is based on actual demonstrations of abilities rather than verbal repertoires alone.

The concept of "least restrictiveness" has been incorporated into many of our public policies. Committing someone to an institution involuntarily is no longer quite as simple as it was. The 94.142 legislation and several judicial decisions have indicated that children may not be moved out of their own school districts or home environments unless a strong case can be made for doing so. Evidence must be provided to show that the placement is really to the client's benefit rather than for the convenience of others. Within behavior modification practice, the concept of least restrictiveness is frequently upheld. The alcoholic patient described above was not put in a hospital but was, instead, treated in the community on his own recognizance as he preferred. The work on treatment of alcoholics in the community (Hunt & Azrin, 1973) and the methods developed by Azrin, Flores, and Kaplan (1975) to assist clients to find jobs, illustrate how the principle of maintaining people within their own community is being applied by behavior analysts.

Many developments in the behavior modification field illustrate a growing emphasis on cost-effectiveness, reflecting Ed's pragmatic bent. Curing bedwetting in three years is not good enough. It needs to take less than a day (or at least less than a month, e.g., Foxx & Azrin, 1974). The same thing with many of the others: Getting rid of nervous habits, getting a job (e.g., Azrin, et al., 1975; Azrin & Nunn, 1977).

The most important concern of Ed's, above all, was the emphasis on the individual: That wherever possible, the individual has maximal input into the specification of the goal of treatment. The client is the focus of the intervention. In many of the helping professions now there is growing emphasis on contracting and similar devices. People are increasingly involved in setting their own goals and often participate in choosing the methods to achieve their goals. Children and other individuals not capable of representing themselves, often are assigned advocates who argue in their behalf.

Despite all the progress of the past decade, abuses still exist, and people are needed to champion reform. Although patients are being allowed to leave mental hospitals, sometimes the conditions of

their release are unconscionable. One day they're there, the next day, they're out on the street. With no skills, no guidance, no supervision, they can become frightened, aimless wanderers, unable to care for themselves. So often they are re-admitted. One newspaper recently reported that the number of people released from mental institutions is the same as those being re-admitted. Obviously, one can't just take a person who has many deviant behaviors (often acquired via institutionalization) and without skills for living in the community and expect that person to be able to function effectively in the outside world. Large rates of readmission are probably a result of the fact that clients are not being adequately trained and that their new environment is not ready to receive and assist them to help themselves. Strategies need to be developed and applied to permit a smoother transition, and a trained staff has to be on hand to supervise the transition.

Similarly, many developmentally disabled children are being prematurely and abruptly separated from institutions. On the basis of Public Law 94.142, it may be decided that an institution is too restrictive for a particular child and that the local school district should take the responsibility. The child might be ejected without any preparation; without the skills of daily living that would permit a reasonable life within the community; without the ability to get along with a group, attend to a task, or perform an occupational skill; or perhaps abusing himself or others.

There are various ways of approaching such problems: Teaching skills of daily living, and community, personal, and social skills prior to the transfer or at the very least concurrent with the transfer. The research literature has presented a broad array of techniques and many materials on self-care and social skills are currently available to accomplish those aims.

Thus, the issue of insufficient preparation for less restrictive placement is one area that remains to be addressed. Another, of course, is a continuing emphasis on the development of effective treatment strategies, for available solutions are still insufficient for current needs. Community systems also need to be analyzed to determine the power structure of the community—the contingencies operating on our school personnel, on service workers, on parents, and others in an attempt to determine the events that support effective programs. The conditions that protect client rights and provide them wider degrees of freedom also need to be investigated further. Another needed area of study is staff training and supervision. Hiring additional personnel is only part of the story. Staff must be adequately trained and supervised, if goals of individual clients are to be promoted optimally (Twardosz, Cataldo, & Risley, 1974).

Lastly, we must continue our effort towards preventing problems in living from developing in the first place. Observations of people who function effectively in their natural environments should provide one source of information. For analyses of the contingencies that promote altruism, the attainment and performance of various skills, social effectiveness, and personally and socially beneficial behaviors, should permit the variables that help prevent problems to be identified. Of course, the field of applied behavior analysis has so much relevance for the area of prevention, since it directs itself towards the discovery of functional relations between behavior and its controlling variables. From those discoveries it has been possible to modify environmental conditions to permit positive changes in behavior or even to promote behaviors that are incompatible with the development of problems in the first place.

In summary, I have tried to trace for you a segment of the life of one individual who had a major impact on the evolution

of the field of behavior analysis. I felt that the story might contribute an interesting facet to its history: How prevailing values interacted with progress in the field and how in turn they affected the human condition. But beyond the historical, I wanted to convey a message: The efforts of single individuals do make a difference towards the righting of wrongs and injustices. Ed exposed himself to criticism and scorn; he invested his time, efforts and emotions. He endured discomfort and rarely enjoyed the long-delayed reinforcements resulting from his efforts. Yet some of those reinforcers have been delivered, too late for him not for others. Progress will continue to be made by those who make similar efforts.

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